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PRIMARY CARE PHYSICIAN INCENTIVE PAYMENT UPDATE

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IN THIS ISSUE

October 26, 1999

DEAR DOCTOR:

For the benefit of new physicians and other interested parties, we are providing an updated explanation of the PCPIP. The PCPIP (Primary Care Physician Incentive Payment) is an attempt to reward those physicians significantly participating in Medicaid for delivering high quality health care. The measures are not set in stone and will change over time, become more sophisticated and hopefully more accurate.

The main goals of the program are simple:

1. Reduce disincentives to having higher Medicaid patient panels.

We want to place the physicians who see a greater number of Medicaid patients and "voluntarily" reduce their potential income, in a position to obtain a larger incentive payment according to their relative peer performance.

2. Reduce inappropriate ER utilization

We are not against "saving" money but the primary goal is to increase the amount of non-emergent primary care delivered in offices and reduce it in the ERs. For any given patient better continuity of care will usually improve the quality of care. As you look at your ER percentile score please consider the characteristics of your practice that may have an influence.

Some characteristics of practices with low ER rates are:

- expanded office hours "evenings, weekends".
- greater physician capacity/availability during office hours.
- better education of patients on what to call the doctor about, what is an emergency, what isn't and what to do about it.
- superior coverage of after office hours – phone availability of physician or nurse, willingness to see after hours or early next morning, etc.

Before the Maine PrimeCare Program began in 1996 in the Aroostook, Piscataquis and Washington counties, the annualized

ER visit rates in these three counties was 1.15. By the end of the second year of the program this ER rate fell to 0.48 (visits/patient/year). Whether Medicaid patients are in the Maine PrimeCare Program or still (hopefully not for long) the traditional fee for service, we are very interested in supporting this trend and appropriately transferring more primary care into physician offices.

3. Increase the Utilization of Preventive Services (and eventually quality measures)

For children we are encouraging all the services/procedures recommended by the Bright Futures Program. These have been adopted by the Bureau of Medical Services as the standard of the EPSDT Program (Early Periodic Screening Diagnosis and Treatment). We have created age specific forms (BF-19) for physicians to use which provide all the required or suggested/optional services. Physicians who maximize both the number of Medicaid patients receiving preventive exams and all age related immunizations, testing, etc. will score well. This also applies to adults but the standards adopted are those of the United States Preventive Services Task Force (USPSTF). In the end, your final composite percentile score is primarily a reflection of how large your Medicaid practice is since this component is weighted at 40%. Therefore, we are not saying or implying that physicians ranked in the lower 20% are "bad" doctors. A number of specialists have been included in this program because they evidently deliver some preventive primary care services. However, the proportion of their Medicaid patients receiving preventive services is relatively small so their scores are lower. **Once the Maine PrimeCare Program is statewide, *only* primary care physicians participating in the Maine PrimeCare Program will be eligible for the PCPIP (estimated time end of year 2000).** Additionally, physicians with low numbers of patients have greater variability in their data making it much less reliable to reach any valid conclusions about relative peer performance. Finally, physicians working for or at Rural Health Centers, Federally Qualified Health Centers, or Hospital/Residency Reimbursed Programs do not qualify for this incentive payment. However, we do intend to create incentive programs over the next several years to specifically address specialists and Health Centers.

For the purpose of this payment you are in a sense "competing" against same specialty physicians with similar panel sizes. Physicians with larger Medicaid panels have a significant advantage. If your patients have lower ER use rates and your preventive/quality scores are higher than average, then you will probably qualify for a higher payment.

We are hoping to continue adding more detailed provider reports to accompany future PCPIP letters.

The last report (PCPIP 5) added lead testing and diabetic care measures for the first time. Future reporting will eventually include 2-year-old immunization levels, avoidable hospital conditions, PAP smear and mammogram rates. We are including a copy of the last PCPIP newsletter (8/13/99) and strongly encourage you to keep these and future PCPIP reports filed together. We are also working towards having all this information available on the State of Maine Internet, Bureau of Medical Services, Quality Division. When this is accomplished you will be notified in the next newsletter.

As you will note, the PCPIP is made out to the billing provider but the report itself is mailed to the physician. You may want to address this with your billing people to be certain the reports are reaching you.

Please address comments to:
Kathy Lavasseur
BMS
11 State House Station
Augusta, ME 04330
207-287-3794

If you need to change your primary specialty, you must send your billing provider number, the servicing providers' numbers whose specialty you want to change, and what specialty you want to:

Provider File Unit
Bureau of Medical Services
11 State House Station
Augusta, ME 04333

The changes to the provider file cannot be done over the telephone. Medicaid requires written documentation to change provider information

COMPONENTS OF SCORING SYSTEM

1. ACCESS – Across all primary care specialties the access component will be weighted 40%. This represents how many individual Medicaid patients were seen in that particular period by that particular physician.

2. ER UTILIZATION – This will also be applied across all primary care specialties and will be weighted 30%. An annual ER utilization rate will be calculated for the group of Medicaid patients each physician is seeing. Eventually this measure will focus on inappropriate ER visits. "Inappropriate" ER visits are those which potentially could have been seen in the office or perhaps could have been prevented altogether by education. (ex. ear infections, URI's, viral infections, etc…)

3. PREVENTION/QUALITY – This group of measures will be specialty specific. It will represent 30% of the score. Some of these measures will change substantially over time and many of the procedures will be rotated periodically.

PEDS Measures are mostly EPSDT related. Physicians will do well by seeing their Medicaid patients at the intervals recommended by the Bright Futures program as adopted by our EPSDT program. Providing services recommended by the Bright Futures/EPSDT age-specific forms will be scored favorably. (immunizations, lead test, hearing test, etc.) *Please note*, under the Bright Futures' guideline, Maine Medicaid encourages and pays for *annual* EPSDT visits from 2 years up to 21 years.

FP/GP Besides incorporating the EPSDT score for children, a preventive score will also be calculated for adults primarily following the United States Preventive Services Task Force (USPSTF) guidelines for recommended screening procedures at specified ages. For example, testing for fecal occult blood and doing flexible sigmoidoscopies will count favorably for certain age groups. Doing PSA's will not count favorably, at least or until the USPSTF guidelines change. Other measures will be added as noted in recent letters.

IM The measures will closely resemble the FP/GP group but will also take into consideration any EPSDT care provided to patients less than 21 years old. We will look for evidence of Hemoglobin A1C testing and annual dilated retinal exams for diabetics.

OB/GYN This will include preventive measures for women as per the USPSTF guidelines. There will also be an obstetric set of measures. This will favor vaginal deliveries, avoiding poor outcomes and appropriately ordering testing during pregnancy. (ex. hepatitis B testing, Rhogam injections for RH negative women, etc…) Very shortly PAP and mammogram rates will be added as detail reports.

PRIMARY CARE PHYSICIAN INCENTIVE PAYMENT

- Effective: 01/01/98
- Total Pool: $750,000/qtr ($3,000,000/yr)
- Payments will be made quarterly

ex. Next period of analysis:01/01/99 – 03/31/99 (PCPIP 6)

Date of analysis: October 1999

Checks mailed: 1st/2nd week November 1999

- Who's eligible – Physicians whose primary specialty is FP, GP, PEDS, IM, OB/GYN *and* who are predominantly practicing primary care.
- Who's not eligible – Physicians working for or as RHC/FQHC's/Hospital/Residency Programs (by end of year 2000 – physicians not enrolled as Maine PrimeCare providers).
- How each specialty share is determined = (a + b) /2

(a) # patients seen by a specialty/# patients seen by all primary care specialties

(b) # of claims by a specialty/# of claims seen by all primary care specialties

ex. for all 1998 FP/GP = 43%
IM = 12%
PEDS = 34%
OB/GYN = 11%

Each physician will have a total score calculated to determine how much or if an incentive payment will be made. Providers below the 20th percentile will not receive any payment.

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In Accordance with Title VI of the Civil Rights Act of 1964 (42 USC § 1981, 2000d et. seq.) Section 504 of the Rehabilitation Act of 1973, as amended (29 USC § 794), the Age of Discrimination Act 1975, as amended (42 USC § 12131 et. seq.), and Title IX of the Education Amendments of 1972, (34 CFR Parts 100, 104, 106 and 110), the Maine Department of Human Services does not discriminate on the basis of sex, race, color, national origin, disability or age in admission or access to or treatment or employment in its programs and actitities. Ann Twombly, Civil Rights Compliance Coordinator, has been designated to coordinate our efforts to comply with the US Department of Health and Human Services regulations (45 CFR Parts 80, 84 and 91), the Department of Justice regulations (28 CFR Part 35), and the US Department of Education regulations (34 CFR Part 106), implementing these Federal laws. Inquiries concerning the application of these regulations and our grievance procedures for resolution of complaints alleging discrimination may be referred to Ann Twombly at 221 State Street, Augusta, Maine 04333, Telephone number: (207) 287-3488 (voice) or 800-332-1003 (TDD), or Assistance Secretary of the Office of Civil Rights of the applicable department (e.g. the Department of Education), Washington, D.C.